No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Second Circuit Court of Appeals, in direct conflict with the decision of the Third Circuit Court of Appeals in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), correctly held that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* (1988 & Supp. IV 1992) preempts sections of New York's Public Health Law which require that hospital rates for patients covered by certain payors be increased by prescribed percentage differentials which have — at most — no more than an indirect economic effect on ERISA plans?

2. Whether the Second Circuit Court of Appeals correctly applied this Court's prior precedents in holding that differentials imposed on certain payors under New York's hospital rate setting law are preempted by ERISA and do not regulate insurance within the meaning of ERISA's savings clause?

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the amended decision of the Second Circuit Court of Appeals which is contained in the Appendix at 1-34. References to the Appendix are hereafter referred to as "A-__".

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Intervenors-Defendants the New York State Conference of Blue Cross & Blue Shield Plans (the "Plans") and Empire Blue Cross and Blue Shield ("Empire")[1] respectfully petition for a writ of certiorari to review the amended opinion dated January 14, 1994 of the United States Court of Appeals for the Second Circuit.

[1] Each of the Plans, including Empire, are not-for-profit corporations operating in accordance with Article 43 of the New York State Insurance Law. As such, they do not have parent companies, subsidiaries or affiliates of the type subject to Rule 29.

OPINIONS BELOW

The original opinion of the Second Circuit Court of Appeals, dated October 25, 1993, is unofficially reported at 62 U.S.L.W. 2290 (2d Cir. Oct. 25, 1993). (A-35-62.) On January 12, 1994, the Second Circuit Court of Appeals granted petitions for rehearing filed by the Plans, Empire, intervenor-defendant Hospital Association of New York State ("HANYS") and by the New York State defendants and directed that "an amended opinion" shall issue forthwith. (A-91-92.) The amended opinion of the Second Circuit Court of Appeals, which was issued on January 14, 1994, is reprinted at A-1-34. The opinion of the United States District Court for the Southern District of New York is officially reported at 813 F. Supp. 996 (S.D.N.Y. 1993). (A-63-90.)

JURISDICTION

On February 7, 1994, the Second Circuit Court of Appeals granted petitioners' motion for a stay of the mandate pending application for a writ of certiorari. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

The relevant provisions of ERISA are reprinted at A-99; the relevant provisions of New York Public Health Law § 2807-c (McKinney 1993) are reprinted at A-101-113.

STATEMENT OF THE CASE

This is a petition for certiorari to review a judgment of the United States Court of Appeals for the Second Circuit which, affirming in part the district court's February 3, 1993 opinion and order, held that three separate differentials of 13%, 11% and 9% on payments for hospital services levied on certain categories of payors, *i.e.*, commercial insurers, health maintenance organizations ("HMOs") and self-funded insurance plans "relate to" employee benefit plans and are therefore preempted by ERISA. The challenged differentials are one

component of New York State's comprehensive and integrated hospital reimbursement scheme which was designed to control hospital costs, to insure that hospitals receive adequate financing and to enable insurers to provide affordable health insurance to all persons regardless of their health. As a result of the Court of Appeals' decision, New York State (the "State" or "New York") is not only now precluded from setting hospital rates in the manner which the State had determined is in the best interest of all its citizens, but the loss of the differential income will also have an immediate effect on services offered to patients in hospitals and jeopardize numerous hospitals now in precarious financial condition.

New York State's Hospital Rate Setting Scheme

New York's hospital rate setting system regulates hospital rates in a manner which limits the amounts hospitals can charge and provides incentives via competitive advantage to insurers whose operations facilitate widespread access to affordable health insurance. In establishing hospital cost controls, the New York legislature divided the various payors for hospital services into three categories. The first category consists of state government (Medicaid), Article 43 corporations, such as each of the Plans[2] (including Empire[1]) and HMOs. *See* N.Y. Pub. Health Law § 2807-c1(a) (McKinney 1993) (A-101). The Plans sell coverage, including Medicare supplemental coverage, to any person

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[2] The Plans is an unincorporated association consisting of all of the Blue Cross and Blue Shield Plans operating in New York State. The Plans are: Empire; Blue Cross and Blue Shield of Utica-Watertown, Inc.; Blue Cross and Blue Shield of Central New York, Inc.; Blue Cross of the Rochester Area, Inc.; Blue Shield of the Rochester Area, Inc.; and Blue Cross and Blue Shield of Western New York, Inc. Each is a not-for-profit health services corporation organized and existing pursuant to Article 43 of the New York Insurance Law.

[1] Empire is by far the largest of the Plans and accounts for some 70% of the hospital coverage contracts written by the Plans. For 1991, Empire reimbursed hospitals $2.5 billion for inpatient hospitalization services rendered to persons Empire covers. Empire affords health coverage to more than 7.5 million persons.

regardless of prior illness, physical condition, age or sex on an open enrollment basis. Unlike commercial carriers, the Plans historically sold health insurance coverage at a uniform community-wide rate otherwise unavailable for high-risk, typically older and less healthy individuals. The Plans also promote financial stability of hospitals. In contrast with commercial carriers, which pay hospitals long after patient costs are incurred, the Plans provide hospitals with advance payments of approximately $300 million in anticipation of claims.[4]

The second category consists of self-insured plans that pay hospitals directly, commercial insurers that are licensed in New York, volunteer firefighters, volunteer ambulance companies and no fault auto insurers. *See* N.Y. Pub. Health Law § 2807-c1(b) (McKinney 1993). (A-102-03.) A third category includes "all others."[5] N.Y. Pub. Health Law § 2807-c1(c) (McKinney 1993). (A-103.)

Hospitals must charge the first two categories of payors strictly regulated cost-based rates that vary depending upon the diagnosis related group or DRG into which that patient falls. *See* N.Y. Pub. Health Law § 2807-c1(a) and (b). (A-101-03.) This rate is calculated pursuant to a complex methodology that reflects the cost of treating an average patient with a particular primary diagnosis and takes into account operating costs for the particular institution, capital costs, malpractice insurance, bad debt and charity care costs, primary health service program costs and physician's excess malpractice insurance.

[4] This working capital advanced by the Plans is of extreme importance to the operations of hospitals because it lessens the need of the hospitals to engage in expensive short term borrowing.

[5] Payors falling within the "all others" category, include "self-pay" patients, patients covered by self-insured groups that do not make direct payments to hospitals and patients covered by commercial insurance policies that do not pay on an expense incurred basis. Payors falling within the all others category pay actual hospital charges subject to a statutory limit and do not have to pay the hospital differentials at issue in this case.

The 13% Hospital Differential

To contain hospital costs and to increase the availability of health insurance coverage to needy New Yorkers, for over ten years New York Public Health Law § 2807-c1(b) has required that payors for hospital services other than the Plans (including Empire), an HMO or government insurance such as Medicaid, pay 13% above the applicable DRG rate. The New York legislature has recently extended the 13% differential from December 31, 1993 to December 31, 1995. 1993 N.Y. Laws, ch. 731, § 35. The 13% differential is paid to hospitals to cover necessary hospital costs, and as noted by the Court of Appeals, the 13% differential was meant to " 'level [the] playing field' " for the Plans "in their competition with commercial insurers." (A-7-8.)

The 11% Hospital Differential

Effective April 2, 1992, and for a period which terminated on March 31, 1993, Section 348 of the Omnibus Revenue Act of 1992 amended N.Y. Pub. Health L. § 2807-c1(b) to provide that hospitals were required to bill commercial insurance companies subject to the DRG rate an additional 11%. 1992 N.Y. Laws, ch. 55, § 348. (A-104). The 11% differential, unlike the 13% differential, was to be paid by the hospitals into the State's general revenue fund. 1992 N.Y. Laws, ch. 55, § 349. (A-105.)

The 9% Hospital Differential

Section 346 of the Omnibus Revenue Act of 1992 subjects HMOs, including those operated by the Plans, to a differential of up to 9% when they fail to enroll a targeted number of Medicaid patients. N.Y. Pub. Health Law § 2807-c2-a(a) to (e) (McKinney 1993). (A-106-13.)[6] The 9% differential to be paid by HMOs, like the 11% differential, is deposited into the State's general revenue fund.

[6] Pursuant to recent legislation, the 9% differential was amended and extended from December 31, 1993 to December 31, 1995. 1993 N.Y. Laws, ch. 731, § 35.

The District Court's Decision

Plaintiffs moved for summary judgment on the grounds that the 13% and 11% hospital differentials are preempted by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8909-8914 (1988 and Supp. IV 1992) and that the 13%, 11% and 9% differentials are preempted by ERISA. The defendants and intervenors – the Plans, Empire and HANYS – cross-moved for summary judgment dismissing the complaints. The district court had jurisdiction of the actions under 28 U.S.C. § 1331 (1988) and 29 U.S.C. § 1132(e)(1) (1988). By Opinion and Order dated February 3, 1993, the Honorable Louis J. Freeh held that ERISA and FEHBA preempt the challenged hospital differentials. (A-68-82 and 84-86.)[7] The district court also rejected the argument that the Tax Injunction Act ("TIA"), 28 U.S.C. § 1341 (1988), barred plaintiffs' challenge to the 11% and 9% differentials, as well as the contention that laches barred claims regarding the 13% differential. (A-66-67.) In addition, the district court ruled that the differentials do not fall within the scope of ERISA's savings clause and are therefore not saved from preemption under this clause. (A-78-82.) Finally, the district court held that four parts of an actuarial letter issued by the New York State Department of Insurance to regulate the issuance of stop-loss insurance contracts by insurance companies to self-insured plans are preempted by ERISA. (A-87-90.) By Memorandum and Order dated February 9, 1993, the district court granted a stay of its Order insofar as it concerned the 13% differential.[8] (A-93-98.)

The Second Circuit's Decision

In its original decision dated October 25, 1993, the Second Circuit Court of Appeals, recognizing that its decision conflicts

[7] Since plaintiffs' motion for summary judgment on the FEHBA issue was limited to consideration of the 13% and 11% differentials, the district court did not decide whether FEHBA preempted the 9% differential.

[8] The district court denied a stay as to the 11% and 9% differentials except that it required plaintiffs to escrow the amounts attributable to these differentials in interest bearing accounts. (A-98.)

with the decision of the Third Circuit in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), nonetheless affirmed the district court's decision that the 13%, 11% and 9% hospital differentials are preempted by ERISA and affirmed the district court's decision that the 13% and 11% differentials do not regulate insurance within the meaning of ERISA's savings clause. (A-46-58.) The Second Circuit also affirmed the district court's decision that the 11% and 9% differentials are not barred by the TIA. (A-43-45.) In addition, the Second Circuit ruled that the plaintiffs' challenge to the 13% differential is not barred by laches. (A-45-46.) Finally, the Second Circuit affirmed the decision of the district court that paragraphs 1, 2, 3 and 5 of an Actuarial Letter issued by the New York State Department of Insurance, which establishes requirements for "stop loss" insurance contracts sold in New York State, are preempted by ERISA but reversed as to paragraph 4 of that letter. (A-58-62.) In view of its decision on ERISA preemption, the Second Circuit ruled that it was not necessary to separately address the plaintiffs' FEHBA preemption challenge to the 11% and 13% differentials. (A-58.)

The Plans, Empire and HANYS then petitioned for rehearing on the grounds that the Second Circuit incorrectly declined to decide the issue of FEHBA preemption and incorrectly ruled that ERISA preempts the challenged hospital rate differentials.[9] The New York State defendants also petitioned the Second Circuit for rehearing with respect to the FEHBA preemption issue. On January 12, 1994, the Second Circuit granted the petitions for rehearing and directed that an "amended opinion" shall issue forthwith. (A-91-92.) The amended opinion of the Second Circuit, which was issued on January 14, 1994, determined that FEHBA preempts the 11% and 13% differentials. (A-12-17.) In other respects, the Second Circuit's amended opinion is identical to its original October 25, 1993 opinion.

[9] On March 7, 1994, the Second Circuit denied the Plans', Empire's and HANYS' suggestion that the court rehear the ERISA preemption issue *in banc*.

REASONS FOR GRANTING THE WRIT

I. A Writ of Certiorari Should Issue Because the Circuits Are Divided Over Whether State Hospital Reimbursement Rate Laws Are Preempted By ERISA

Whether state hospital reimbursement rate laws are preempted by ERISA is an important issue that divides the circuits. The Third Circuit in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir. 1993), recently upheld New Jersey's hospital rate reimbursement law against an ERISA preemption challenge that was essentially identical to the challenge to New York's regulatory rate scheme. Like New York's rate setting scheme, New Jersey assigns a rate to various medical procedures which are classified into DRGs. *Id.* at 1189. Also, like New York's rate setting system, New Jersey requires certain classes of payors to pay additional differentials or surcharges above the basic DRG rates.[10] *Id.* As in this case, the plaintiffs in *United Wire* challenged the additional differentials on grounds of ERISA preemption.

After reviewing the relevant Supreme Court decisions which have analyzed ERISA's preemption clause, the Third Circuit in *United Wire* concluded that "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans, the cases which have cordoned off this area of preemption are inapplicable."

[10] Under New Jersey's hospital rate setting system, high volume plans are granted a discount of 2.2% on hospital rates for prompt payment, and plans with open enrollment are granted a discount of 11% on hospital rates. Plans qualifying for both discounts receive a total discount of 13.2% on hospital rates. The 13.2% discount is substantially similar to and has the same effect as the 13% differential added to hospital rates for payors other than the Plans (including Empire), an HMO or government insurance such as Medicaid under New York's hospital rate setting system.

United Wire, 995 F.2d at 1192.[11] While acknowledging that New Jersey's rate setting scheme may increase the charges billed to ERISA plan participants for hospital services, the Third Circuit, relying on the Supreme Court's decision in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), found that "[t]his effect is no different in kind, however, from any state regulation that increases the cost of goods or services, . . . *i.e.*, utility costs, the wages of its employees, waste disposal costs, etc." 995 F.2d at 1193. The Third Circuit in *United Wire* concluded that the "mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated." *Id.*

Concluding that ERISA preempts the statutory differentials mandated by New York's hospital rate setting scheme, the Second Circuit expressly acknowledged that:

> To the extent that our holding conflicts with *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, we decline to follow it. . . . [W]e also believe that the Third Circuit reads ERISA's preemption clause too narrowly.

(A-24-25) (citations omitted). In contrast to the Third Circuit, the Second Circuit held that "[w]hile the challenged statutes do not refer to ERISA plans," (A-22) they are preempted by ERISA solely by imposing "significant" economic burdens on employee benefit plans. (A-24.) In so holding, the Second Circuit

[11] The Third Circuit's decision in *United Wire* is consistent with ERISA preemption decisions of the Ninth and Tenth Circuit Courts of Appeals which have repeatedly found that a variety of laws of general application, which may impact ERISA plans in some fashion, are not preempted by ERISA. *Monarch Cement Co. v. Lone Star Indus., Inc.*, 982 F.2d 1448 (10th Cir. 1992) (ruling that ERISA did not preempt a state law interpretation of a sale agreement relating to a retirement plan); *Hospice, Inc. v. Group Health Ins., Inc.*, 944 F.2d 752 (10th Cir. 1991) (ruling that ERISA did not preempt hospital's state law collection action against insurance company); *Retirement Fund Trust v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990) (concluding that California tax collection procedures were not preempted by ERISA); *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984) (determining that ERISA did not preempt statute prohibiting employment discrimination).

concluded that the entirety of its prior decision in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), which had rejected a similar ERISA-preemption challenge to New York's Public Health Law, has been abrogated by the subsequent decision of the Supreme Court in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).[12] In support of its ruling, the Second Circuit broadly interpreted the Supreme Court's decision in *Ingersoll-Rand* and found that the challenged differentials "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand*" because it increased hospital costs for patients covered by ERISA plans thereby interfering with the "choices that ERISA plans make for health care coverage." (A-22.)

At odds with the Second Circuit's decision, *United Wire*, 995 F.2d at 1194, did not so distend *Ingersoll-Rand* as to require the complete invalidation of *Rebaldo v. Cuomo*. Although agreeing that *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), rejected the portion of *Rebaldo's* analysis which reasoned that to be preempted a state law must "purport to regulate the terms and conditions" of benefit plans, *United Wire*, nevertheless, ruled that *Ingersoll-Rand* did not affect *Rebaldo*'s holding that ERISA does not preempt generally-applicable state laws which have no more than an indirect economic impact on benefit plans.[13] *United Wire* concluded that *Rebaldo* "would have been decided in the same way if the court had had the benefit of the teachings of *Ingersoll-Rand*." *United Wire*, 995 F.2d at 1194.

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[12] In *Rebaldo v. Cuomo*, the Second Circuit rejected an ERISA-preemption challenge to New York Public Health Law § 2807-a(6)(b), which precluded self-insured benefit plans from negotiating rates with hospitals lower than those fixed by law, and ruled that the state law does not "relate to" benefit plans within the meaning of ERISA's preemption provision "by increasing their costs of doing business" in New York. *Id.* at 138. In support of its conclusion, the Second Circuit in *Rebaldo* noted that the containment of hospital costs was a proper exercise of the State's police powers. *Id.*

[13] Rebaldo's analysis of when a state statute generally applied has an indirect economic impact which is too remote and tenuous to be said to relate to a plan was reaffirmed by the Second Circuit in *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), and, until *Travelers*, was the law of the Second Circuit.

In striking down the challenged differentials, the Second Circuit in *Travelers Ins. Co. v. Cuomo* failed to cite any legislative history indicating that Congress intended to preempt state hospital reimbursement laws, let alone evidence that it was a clear and manifest purpose of Congress. Where, as here, the purpose of the state statute is the regulation of public health and the cost of hospital care, all of which are plainly state exercises of traditional police power, the state law should be preempted only if that is the " 'clear and manifest purpose' " of Congress. *Hillsborough County v. Automated Medical Labs., Inc.*, 471 U.S. 707, 715 (1985) (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977)); *Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 206 (1983); *Medical Society v. Cuomo*, 976 F.2d 812 (2d Cir. 1992); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989); *Van Camp v. AT & T Information Servs.*, 963 F.2d 119 (6th Cir.), *cert. denied*, 113 S. Ct. 365 (1992); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992).

The Third Circuit, on the other hand, found that ERISA was not intended to frustrate the efforts of a state to regulate health care costs, noting that "there are many forms of state regulation under the police power which result in increases in the cost of doing business and corresponding increases in prices where the beneficiaries of the regulation are not those who are paying the increased prices." *United Wire*, 995 F.2d at 1196. *United Wire*, in direct conflict with the Second Circuit, concluded that "[s]uch regulations can significantly increase a hospital's cost of doing business and, accordingly, its billings to plan participants. We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind." *Id.*

In sum, the Second Circuit has rendered a decision squarely in conflict with a decision of the Third Circuit. This Court should grant certiorari to resolve these conflicting interpretations of the scope of ERISA's preemption provision with respect to state hospital rate reimbursement schemes.

II. The Second Circuit's Decision Is Not Supported By ERISA Preemption Decisions of the Supreme Court

A. Supreme Court Decisions Do Not Support the Second Circuit's Conclusion that New York's Statutory Differentials Relate to ERISA Plans

Travelers Ins. Co. v. Cuomo also warrants review because it is not supported by ERISA preemption decisions of the Supreme Court. ERISA preempts state laws which "relate to" an employee benefit plan covered under ERISA, 29 U.S.C. § 1144(a) (1988).[14] The Supreme Court has stated that a state law "relates to" a benefit plan "if it has a connection with or reference to such a plan." *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). But, ERISA's preemption clause is not without limits. In general, ERISA does not preempt state laws that "affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. Falling outside the scope of ERISA's preemption provision is a "generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.[15] This standard was recently affirmed by the Court in *District of Columbia v. Greater Washington Board of Trade*:

> Pre-emption does not occur, however, if the state law has only a "tenuous, remote, or peripheral" connection with covered plans, as is the case with many laws of general applicability.

[14] Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides that "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

[15] In *Ingersoll-Rand*, the plaintiff sued under state common law claiming that he had been discharged because his employer sought to avoid making pension plan contributions on his behalf. The Court found that since "the existence of a pension plan is a critical factor in establishing liability under the State's . . . law," the state law action was preempted because it "relates not merely to pension benefits, but to the essence of the . . . *plan* itself." *Id.* at 139-40.

113 S. Ct. at 583 n.1 (citation omitted).

The Supreme Court has also refused to invalidate a state law merely because the law results in a depletion of a benefit plan's available assets, even though such a law would obviously affect the operation of the plan. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988).[16] Finally, the Court has ruled that where a state law in question does not impinge upon the ongoing "administrative practices of a benefit program," it "in no way raises the types of concerns that prompted pre-emption." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987).[17] While ERISA was designed to safeguard the financial soundness of employee benefit plans, *see* 29 U.S.C. § 1001, the Court has never invalidated a state law merely because it economically impacts ERISA plans by increasing the cost of conducting business. Just to the contrary, however, the Second Circuit held:

> In sum, Judge Freeh properly found that the three surcharges "relate to" ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration. Accordingly, the statutes at issue here are preempted . . . .

(A-24-25.)

Indeed, the Second Circuit's decision is not supported by the Supreme Court's decision in *Mackey*, where the Court refused to

[16] In *Mackey*, the Supreme Court ruled that ERISA does not preempt state garnishment procedures which permit the garnishment of plan benefits to execute judgments against plan participants, finding that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits." *Id.* at 831-32.

[17] In *Fort Halifax*, the Supreme Court held that a Maine statute requiring employers to provide one-time severance payments to employees when a plant closes was not preempted by ERISA. *Id.* at 19.

preempt Georgia's garnishment statute even though application of that law would have economic consequences for ERISA plans. Significantly, the Second Circuit did not cite a single Supreme Court precedent in support of its holding. (A-23-24.)[18]

Moreover, as the Second Circuit conceded, the challenged hospital rate differentials do not refer to ERISA benefit plans (A-22), unlike the statute which the Court invalidated in *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580, 583 (1992). In fact, the challenged differentials nowhere mention employee benefit plans. They apply generally to fees charged by hospitals to many classes of payors including Article 43 corporations, commercial insurers and self-insured groups.[19] Similarly, unlike the state cause of action in *Ingersoll-Rand*, which was predicated on the existence of an employee benefit plan, the challenged differentials in this case do not base liability on the existence of a benefit plan. The challenged differentials neither regulate the affairs of ERISA benefit plans nor single out ERISA plans for special treatment. Some persons insured by Article 43 corporations are members of ERISA plans;

[18] The Supreme Court has never adopted the "significant economic impact" standard applied by the Second Circuit in *Travelers*. The Second Circuit's "impact" standard is similar to the "direct and substantial effect" standard applied by the Supreme Court in field preemption cases. *See English v. General Elec. Co.*, 496 U.S. 72, 79, 85 (1990); *Gade v. National Solid Wastes Management Ass'n*, 112 S. Ct. 2374, 2386-87 (1992). Field preemption cases, however, unlike ERISA preemption cases, do not contain statutory language defining the scope of preemption and are therefore distinguishable from ERISA-preemption cases. Thus, it appears that the Second Circuit has applied an incorrect standard of preemption to invalidate New York's hospital rate differentials.

[19] Nevertheless, the Second Circuit relied on the decision of the Fifth Circuit in *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991), which involved a state tax applied directly to a plan's assets ("The tax is calculated as, *inter alia*, a percentage of all claims paid and disbursements made by the plans each year."). Indeed, the state tax law in *E-Systems, Inc. v. Pogue* expressly referred to "any employer-employee, . . . self-insurance group . . . or health benefit plan" and is plainly distinguishable from the hospital rate differentials at issue here. *Id.* at 1101.

some are not. Similarly, some persons covered by commercial insurance or self-insured groups are members of ERISA plans; some are not. The challenged hospital differentials are simply state laws of general application designed to advance the State's goals of hospital cost containment and widespread access to affordable health insurance. Moreover, the only effect that the differentials have on ERISA benefit plans is indirect and economic in nature. The Supreme Court has never held that indirect economic impact, standing alone, is sufficient to justify a finding of preemption.

B. Supreme Court Precedent Does Not Support the Second Circuit's Refusal to Find that the Differentials Are Saved From Preemption

Supreme Court decisions, moreover, do not support the Second Circuit's conclusion in *Travelers* that the challenged differentials do not regulate insurance within the meaning of ERISA's savings clause.[20] (A-25-29.) In *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740-41 (1985), the Supreme Court construed ERISA's savings clause to cover state public health laws which indirectly regulate insurance unlike "traditional" insurance laws. Similar to the state law at issue in *Metropolitan Life*,[21] the challenged differentials are part of an integrated system intended to contain hospital costs while increasing the availability of affordable hospital insurance

[20] ERISA's savings clause provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A) (1988).

[21] The Massachusetts statute at issue in *Metropolitan Life Ins. Co. v. Massachusetts* required that a health-insurance policy provide certain minimum mental health care benefits in order to address problems encountered in treating mental illness, including the containment of high treatment costs, and to encourage more effective treatment of persons with mental illness in outpatient settings. *Id.* at 730-31.

coverage by effectively forcing good risks to become part of the risk pool. The Second Circuit, however, failed to follow the Supreme Court's broad "common sense view" of the language of the savings clause to cover public health laws which indirectly regulate insurance. *Id.* at 740. *See also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990)(stating that Pennsylvania's anti-subrogation law falls within ERISA's savings clause).

Instead, *Travelers* narrowly interpreted the savings clause to exclude the challenged differentials because, in the words of the Second Circuit, the differentials "expressly regulate hospital rates" and "do not directly implicate the policy relationship between insurers and their insureds." (A-29.) This conclusion, inconsistent with the Second Circuit's own finding in *Travelers* that the 13% and 11% differentials are "*designed* to encourage ERISA plans – with generally healthier persons – to shift to the Blues", (A-28) (emphasis added), which would help spread the risk of health care costs, incorrectly ignores the Supreme Court's acknowledgment in *Metropolitan Life*, 471 U.S. at 741, that laws with a public health purpose may nevertheless be saved as regulating insurance.

Moreover, the Second Circuit's conclusion that the differentials are not saved from preemption under ERISA's savings clause because all three McCarran-Ferguson Act criteria[22] are not satisfied, is also not supported by Supreme Court decisions. (A-25-29.) While the Supreme Court in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. at 129, stated that none of the McCarran-Ferguson Act criteria is determinative, the Court did not hold that all three criteria have to be satisfied to regulate the business of insurance which the Second Circuit now seems to require.

[22] As stated in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985), "[c]ases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within that Act's reference to the "business of insurance"; "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Id.* (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

The Second Circuit's decision therefore is not supported by ERISA preemption decisions of the Supreme Court and warrants review.

III. The Second Circuit's Decision Raises an Important Issue That Will Recur If Not Reviewed By the Court

By invalidating, under ERISA, New York State's mandatory differentials hospitals charge different categories of payors for their services, the Second Circuit's decision may negatively impact upon New York's entire reimbursement system, as well as other state systems nationwide.[23] In this regard, the district court noted that given the breadth of ERISA preemption, "ERISA [may] preempt[ ] all state hospital rate-setting statutes, at least to the extent they apply to rates charged to patients that are participants in ERISA plans which include hospital expenses as a benefit." *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. at 1006.[24] (A-77-78.) In the short run, the district court observed that "in the absence of some other, immediately available source of income, loss of the 13% Surcharge will cause a substantial and irreparable disruption in the functioning of and services provided by New York's hospitals." (A-96.)

[23] *Travelers* has the potential of invalidating New York State's entire integrated scheme for the delivery of health services, including recent enactments and regulations which require community rating and open enrollment with respect to health insurance coverage. This is evidenced by a recent district court decision in *New York State Health Maintenance Organization Conference v. Curiale*, 93 Civ. 1298 (MBM) (S.D.N.Y.). On March 1, 1994, District Court Judge Michael B. Mukasey, relied exclusively on *Travelers* in enjoining as to HMOs a newly promulgated New York State insurance regulation which is an integral part of the implementation and operation of health insurance reform law in New York State.

[24] In addition, under the Second Circuit's analysis in *Travelers Ins. Co. v. Cuomo*, any state regulation that increases the cost of goods or services that hospitals consume and which results in an increase in the charges billed to ERISA plan participants for hospital services may be preempted. As the Third Circuit noted in *United Wire*, such a conclusion would result in the preemption of all types of state regulations, including "rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees." *United Wire*, 995 F.2d at 1194.

If left standing, the decision of the Second Circuit will disrupt the provision of health services to millions of hospital patients and threaten the State's comprehensive and integrated hospital reimbursement scheme. In addition, the decision fails to establish a workable standard for determining when a state law places an impermissible "significant" economic burden on an employee benefit plan. In holding that New York's hospital rate differentials of 13%, 11% and 9% impose a "significant" economic burden upon employee benefit plans, the Court of Appeals distinguished a .6% assessment on hospital gross receipts which was unsuccessfully challenged in *NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146 (S.D.N.Y. Feb. 23, 1993), because its economic impact on the plan was "*de minimis*." (A-24.) One can only guess whether in the Second Circuit's opinion the economic impact of a new hospital rate scheme containing a differential at a rate somewhere between .7% to 8% would be considered "significant" and, therefore, be held preempted. As a result, the Second Circuit's decision will not prevent the issue from recurring.[25] Review of the Second Circuit's decision is necessary for a final resolution of these important issues.

[25] In that regard, the Second Circuit's decision also fails to establish a clear standard for district courts to follow in several pending cases which raise similar ERISA preemption issues. *See Trustees of and the Pension, Hospitalization Benefit Plan v. Cuomo*, No. 92-5589 (E.D.N.Y. Nov. 25, 1992) (challenging the bad debt and charity care allowance under New York's Public Health Law) and *Connecticut General Life Ins. Co. v. Cuomo*, No. 93-3648 (S.D.N.Y. May 27, 1993) (challenging New York's balance billing and DRG rate setting system).

CONCLUSION

For all of the foregoing reasons, the petition for a writ of certiorari should be granted.

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Respectfully submitted,

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